

<i>SERFF Tracking Number:</i>	<i>NWST-126046916</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Northwestern Mutual Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42030</i>
<i>Company Tracking Number:</i>	<i>MN 992-LTD/0209</i>		
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.003 Long Term</i>
<i>Product Name:</i>	<i>MN 992-LTD/0209</i>		
<i>Project Name/Number:</i>	<i>MN 992-LTD/0209/MN 992-LTD/0209</i>		

Filing at a Glance

Company: The Northwestern Mutual Life Insurance Company

Product Name: MN 992-LTD/0209

TOI: H11G Group Health - Disability Income

Sub-TOI: H11G.003 Long Term

Filing Type: Form

SERFF Tr Num: NWST-126046916 State: ArkansasLH

SERFF Status: Closed

Co Tr Num: MN 992-LTD/0209

Co Status:

Authors: Nicole Markey, Alan Smith Disposition Date: 04/06/2009

Date Submitted: 04/01/2009

State Tr Num: 42030

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: MN 992-LTD/0209

Project Number: MN 992-LTD/0209

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 03/05/2009

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer, Association, Trust, Other

Explanation for Other Group Market Type: Union

State Status Changed: 04/06/2009

Corresponding Filing Tracking Number: MN 992-LTD/0209

Filing Status Changed: 04/06/2009

Deemer Date:

Filing Description:

The Northwestern Mutual Life Insurance Company is filing changes to our Group Long Term Disability Insurance product for review and approval.

Northwestern's Group LTD product is filed under Group Policy Form MN 992-LTD and Group Certificate Form MN 992-LTDC were approved for use in your state effective July 30, 1993. The purpose of this filing is to update policy language

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and provide new optional provisions for any Policyowner to select.

Enclosed are duplicate copies of Group Policy Amendment Form MN 992-LTD/0209 and the corresponding Group Certificate Attachment Form MN 992-LTDC/0209.

The specific design of each group policy is negotiated and agreed upon by Northwestern Mutual and the Policyowner at the time of policy issue. The appropriate language is then automatically included in the body of the policy and certificate. While the attached forms are submitted on 8 ½ by 11 pages, we may also print the same text in a booklet format (5 ½ by 8 ½ pages) or on electronic media (e.g. CD-ROM, Internet), if requested by the Policyowner. We may also issue certificates in a foreign language, based upon a direct translation of the filed wording.

There is no deviation from generally accepted insurance practices.

This group insurance product is, and will continue to be, marketed through normal insurance channels (insurance brokers and representatives) to groups traditionally eligible for group insurance. The majority of group policies will be issued to employers to cover their employees.

The attached forms meet and exceed the requirements of the Arkansas Life and Disability Insurance Policy Language Simplification Act, when included within the base policy and certificate.

Company and Contact

Filing Contact Information

Nicole Markey, Compliance Analyst	nmarkey@standard.com
900 SW Fifth Avenue	(971) 321-2427 [Phone]
Portland, OR 97204	(971) 321-8369[FAX]

Filing Company Information

The Northwestern Mutual Life Insurance Company	CoCode: 67091	State of Domicile: Wisconsin
720 East Wisconsin Avenue	Group Code: 860	Company Type: Life
Rm S845		
Milwaukee, WI 53202	Group Name:	State ID Number:

(414) 665-4224 ext. [Phone] FEIN Number: 39-0509570

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Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	Arkansas charges \$50.00 per filing package. We are sending one package.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Northwestern Mutual Life Insurance Company	\$50.00	04/01/2009	26884396

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/06/2009	04/06/2009

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Disposition

Disposition Date: 04/06/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Policy Amendment	Approved-Closed	Yes
Form	Certificate Attachment	Approved-Closed	Yes

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Product Name: MN 992-LTD/0209

Project Name/Number: MN 992-LTD/0209/MN 992-LTD/0209

Form Schedule

Lead Form Number: MN 992-LTD/0209

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	MN 992-LTD/0209	Policy/Cont	Policy Amendment ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0	NM 209 rider .pdf
Approved-Closed	MN 992-LTDC/0209	Certificate	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0	NM 209 cert.pdf

AMENDMENT TO GROUP LONG TERM DISABILITY INSURANCE POLICY FORM

Attached to and made a part of Group Policy Form MN 992-LTD

Group Policy Form MN 992-LTD is amended to update policy language, and include the following provisions for any Policyowner who negotiates inclusion of such language into its Long Term Disability policy issued by us. The use of brackets ([]) indicate the language is optional or variable; optional language is either included or removed in entirety, while variable language shows possible language choices or the most common number range used within the brackets.

1. In order to provide a definition of Spouse, **SECTION 2.2 BENEFIT TERMS** is amended as follows:

[Optional;

[Variable;

Spouse. Spouse is defined as follows:

- * A person to whom you are legally married; or
- * Your Domestic Partner. Your Domestic Partner means an individual recognized as such under applicable law.

-or-

- * A person to whom you are legally married; or
- * Your Domestic Partner. Domestic Partner means an individual with whom you have completed an affidavit of declaration of domestic partnership, submitted that affidavit to the Employer, and filed that affidavit for public record if required by law; or an individual recognized as your Domestic Partner under applicable law.]]

2. In order to provide an Own Specialty Definition of Disability for dentists, the Own Occupation Definition of Disability located in **SECTION 2.3 DEFINITION OF DISABILITY**, is amended to add the following language:

[Optional;

However, if your Own Occupation is **[Variable; dentist]**, during the period preceding your Beginning Date and throughout **[Optional; the first [Variable; ranges from 12 to 60] months of]** the Own Occupation Period, the Company will consider your Own Occupation to be the **[Optional and Variable; ranges from one to five] [Variable; dental] [Variable; specialty/specialties]** in which you are board certified to practice **[Optional; for which there is a specialty recognized by the [Variable: American Dental Association],]** provided you have earned at least **[Variable; ranges from 50 to 90]%** of your gross professional service fee income in your **[Variable; specialty/specialties]** during the **[Variable; ranges from 24 to 48] months** immediately before you become Disabled.]

3. In order to provide working claimants a benefit of the greater of certain amounts, the Group Policy is amended as follows:

- a. **SECTION 2.5 BENEFIT AMOUNTS**, is amended to include the following optional language

[Optional;

If you have Work Earnings, the Company will pay the greater of the following benefits:]

[Optional:

However, if you have at least an 80% Loss of Earnings, the Proportionate Benefit amount will be 100% of the LTD Benefit. In no event will the amount payable be more than 100% of the LTD Benefit.]

- b. In the **SPECIFICATIONS** section, item **2.5 BENEFIT AMOUNTS**, is also amended to include the following language:

[Optional;

If you have Work Earnings, the Company will pay the greater of the following benefits:]

[Optional:

If you have at least an 80% Loss of Earnings, the Proportionate Benefit amount will be 100% of the LTD Benefit.]

4. In order to provide an Employer Income Protection Benefit, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language

[Optional;

[Variable; 2.13] EMPLOYER INCOME PROTECTION BENEFIT

Insuring Clause. **[Optional;** During the period preceding the Beginning Date and] while **[Variable; LTD Benefits]** are payable to a **[Variable; Member –or- Key Person]**, an Employer Income Protection (EIP) Benefit will be paid to the **[Variable; Member’s –or- Key Person’s]** Employer according to the terms of the Policy.

Key Person. Key person means a **[Variable; President, Sr. Vice President, Key Producer]**.

Schedule. The EIP Benefit Period is **[Variable; 6 to 24]** months or the period **[Variable; LTD Benefits]** are payable, whichever is shorter.

Employer Income Protection Amount. The amount of the EIP Benefit is:

Formula 1; **[Variable; 10 to 100]**% of the **[Variable; Member’s –or- Key Person’s]** Indexed Predisability Earnings, subject to the **[Variable; Maximum Benefit]**. See Specifications.

However, if the **[Variable; Member’s –or- Key Person’s]** Work Earnings exceed **[Variable; 10 to 50]**% of the **[Variable; Member's –or- Key Person's]** Indexed Predisability Earnings, the following Formula 2 will be used to determine the amount of the EIP Benefit.

Formula 2; (A divided by B) times C, where:

A = The **[Variable; Member’s –or- Key Person’s]** Indexed Predisability Earnings, minus the **[Variable; Member’s –or- Key Person’s]** Work Earnings.

B = The **[Variable; Member’s –or- Key Person’s]** Indexed Predisability Earnings.

C = The amount determined in Formula 1.

The EIP Benefit will **[Optional; not]** be reduced by Deductible Income.

When EIP Benefits End. EIP Benefits end automatically on the earliest of:

- * The date the EIP Benefit Period Ends.
- * The date the Employer ceases to employ the [Variable; Member –or- Key Person].
- * The date the [Variable; Member –or- Key Person] becomes employed by another employer.
- * The date the Policy terminates.]

- b. In the **SPECIFICATIONS** section, **SECTION 2. BENEFITS** is also amended to include the following language:

[Optional;

[Variable; 2.13] EMPLOYER INCOME PROTECTION BENEFIT

Formula 1:

[Variable; 10 to 100]% of the [Variable; Member's –or- Key Person's] Indexed Predisability Earnings, subject to the Maximum Benefit.

However, if the [Variable; Member's –or- Key Person's] Work Earnings exceed [Variable; 10 to 50]% of the [Variable; Member's –or- Key Person's] Indexed Predisability Earnings, the following Formula 2 will be used to determine the amount of the EIP Benefit.

Formula 2: (A divided by B) times C, where:

A = The [Variable; Member's –or- Key Person's] Indexed Predisability Earnings, minus the [Variable; Member's –or- Key Person's] Work Earnings.

B = The [Variable; Member's –or- Key Person's] Indexed Predisability Earnings.

C = The amount determined in Formula 1.

5. In order to add an optional **SPECIAL DISMEMBERMENT PROVISION**, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language:

[Optional;

[Variable; 2.14] SPECIAL DISMEMBERMENT PROVISION

If you suffer a Loss as a result of an accident [Optional; or exposure to the natural elements], you will be considered Disabled for the applicable Minimum Benefit Period [Variable; subject to the Maximum Benefit Period –or- even if this causes [Variable; LTD Benefits] to be payable beyond the end of the Maximum Benefit Period].

Definition Of Loss. Loss means loss of hand, foot, or sight [Optional; , speech or hearing,] [Optional; or thumb and index finger of the same hand] which:

- * Is caused solely and directly by an accident [Optional; or exposure to the natural elements];
- * Occurs independently of all other causes;

- * Occurs within 90 days after the accident;
- * Occurs while you are insured under the Policy **[Optional; , unless the Policy terminates after the date of the accident and you are continuously Disabled from the date the Policy terminates to the date of the Loss].**

With respect to a hand or foot, Loss means actual and permanent severance from the body at or above the wrist or ankle joint.

With respect to sight, Loss means entire and irrecoverable loss of sight.

[Optional;

With respect to speech or hearing, Loss means entire and irrecoverable loss of audible speech or hearing, as certified by a Diplomate of the American Board of Otolaryngology.]

[Optional;

With respect to thumb and index finger of the same hand, Loss means actual and permanent severance from the body at or above the metacarpophalangeal joints.]

Minimum Benefit Period. The Minimum Benefit Period for a Loss of one hand, one foot, or sight of one eye, **[Optional; or speech or hearing,] [Optional; or thumb and index finger of the same hand]** is **[Variable; 1 to 12] months [Optional; or to the end of the Maximum Benefit Period, whichever is shorter].** The Minimum Benefit Period for two or more of the above Losses is **[Variable; 2 to 24] months [Optional; or to the end of the Maximum Benefit Period, whichever is shorter].**

You will not be considered Disabled for more than the longer Minimum Benefit Period described above with respect to all Losses from the same accident **[Optional; or exposure to the natural elements].**

The Minimum Benefit Period begins **[Variable; on the Beginning Date –or- on the date of the Loss].** The Minimum Benefit Period counts as part of the Maximum Benefit Period.

[Optional;

During the Minimum Benefit Period your **[Variable; LTD Benefit]** will not be reduced by sick pay or other salary continuation paid to you by your Employer or by your Work Earnings.]

Exclusions. No **[Variable; LTD Benefit]** is payable under this provision if the Loss is caused or contributed to by any of the exclusions listed in the section entitled **Exclusions and Limitations [Optional; or any of the following]:**

[Optional;

- * War or act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.]

[Optional;

- * Attempted suicide or other intentionally self-inflicted injury, while sane or insane.]

[Optional;

- * Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.]

[Optional;

- * The voluntary use or consumption of any poison, chemical compound or drug, unless used or consumed according to the directions of a physician.]

[Optional;

- * Sickness, Injury, or Pregnancy existing at the time of the accident.]

[Optional;

- * Heart attack or stroke.]

[Optional;

- * The use or consumption of alcohol or your alcoholism.]

[Optional;

- * Medical or surgical treatment for any of the above.]]

- b. In the **SPECIFICATIONS** section, **SECTION 2. BENEFITS** is also amended to add the following language:

[Optional;

[Variable; 2.14] [Variable; SPECIAL DISMEMBERMENT PROVISION]

Loss of one hand, one foot, or sight of one eye **[Optional;** or period, speech or hearing,] **[Optional;** or thumb and index finger of the same hand]:

Minimum Benefit Period is **[Variable; 1 to 12]** months **[Optional;** or to the end of the Maximum Benefit whichever is shorter].

Loss of two or more of the above:

Minimum Benefit Period is **[Variable; 2 to 24]** months **[Optional;** or to the end of the Maximum Benefit Period, whichever is shorter].]

6. In order to add a **MEDICAL EXPENSE BENEFIT**, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language:

[Optional;

[Variable; 2.15] MEDICAL EXPENSE BENEFIT. The Company will pay a Medical Expense Benefit to you according to the rules below:

- * **[Variable;** LTD Benefits are payable to you **–or–** You are receiving LTD Benefits] **[Optional;** and you have been continuously Disabled for at least **[Variable; 1-365 days].**

- * The amount of the Medical Expense Benefit is [Variable; [Variable; \$50 to 20,000 -or- [Variable; 10 to 80% of your [Variable; Predisability Earnings -or- LTD Benefit]] [Variable; per month -or- in a lump sum] [Variable; or the actual monthly amount of your medical premiums you pay for yourself [Optional; and your family] if less].
- * The Medical Expense Benefit is payable [Variable; for a maximum of [Variable; 1 to 60] months -or- to the end of the Maximum Benefit Period] [Variable; for each period of Disability -or- once in your entire lifetime].

[Optional;

- * The Medical Expense Benefit amount will be first applied to reduce any overpayment of your claim.]

[Optional;

- * The Medical Expense Benefit amount will be adjusted in conjunction with the [Variable; LTD Benefit] by the same Indexing Factor used to adjust your [Variable; LTD Benefit]. See **Indexed Income Benefit.**

[Optional;

- * Medical Expense Coverage may [Optional; not] be continued under the **Conversion of Insurance** provision.]]

- b. In the **SPECIFICATIONS** section, **SECTION 2. BENEFITS** is also amended to add the following language:

[Optional;

[Variable; 2.15] **MEDICAL EXPENSE BENEFIT**

Amount: The amount of [Variable; the Medical Expense Benefit] is [Variable; [Variable; \$50 to 20,000 -or- [Variable; 10 to 80% of your [Variable; Predisability Earnings -or- LTD Benefit]] [Variable; per month -or- in a lump sum] [Variable; or the actual monthly amount of your medical premiums you pay for yourself [Optional; and your family] if less].]

7. In order to add a **FAMILY CARE EXPENSES ADJUSTMENT** provision, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language:

[Optional;

[Variable; 2.16] **FAMILY CARE EXPENSES ADJUSTMENT.** If you must pay Family Care Expenses in order to work, the Company will reduce the amount of the Work Earnings used in determining your Loss Of Earnings, subject to the following:

- * Your Work Earnings will be reduced by the first \$[Variable; 250] per Family Member of the monthly Family Care Expenses you pay, but not to exceed a total of \$[Variable; 500] for all Family Members.
- * The Work Earnings and the Family Care Expenses must be for the same period.

- * You must give the Company satisfactory proof of the Family Care Expenses you pay.
- * The Work Earnings reduction by Family Care Expenses will end [**Variable; 12 months**] after it begins.

Family Care Expenses. This is the amount you pay to a licensed care provider for the care of your Family Member which is necessary in order for you to work.

Family Member. This includes:

- * Your Child; or
- * Your Spouse, parent, grandparent, sibling, or other close family member residing in your home who is;
 - (1) Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
 - (2) Chiefly dependent upon you for support and maintenance.

Child. This includes:

- * Your child residing in your home (including your stepchild an adopted child), from live birth through age [**Variable; 11**]; or
- * Your child, age [**Variable; 12**] or older, residing in your home (including your stepchild and an adopted child) who is;
 - (1) Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
 - (2) Chiefly dependent upon you for support and maintenance.]

- b. In the **Specifications** section, **SECTION 2. BENEFITS** is also amended to add the following language:

[**Optional;**

[**Variable; 2.16**] **FAMILY CARE EXPENSES ADJUSTMENT** [**Variable; Yes –or- No**]

8. In order to add an **ADDITIONAL BENEFITS FOR THE SEVERELY DISABLED** provision, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language:

[**Optional;**

[**Variable; 2.17**] **ADDITIONAL BENEFITS FOR THE SEVERELY DISABLED**

[**Optional;**

Lifetime Security Benefit. If you meet the requirements below on the date your Maximum Benefit Period ends, LTD Benefits will be payable beyond the end of your Maximum Benefit Period [**Optional; for an additional [Variable; 1 to 40 years]**, according to the terms of the Policy after the Company receives satisfactory Proof Of Loss.]

Requirements For Lifetime Security Benefit:

- * Benefits are scheduled to end solely because your Maximum Benefit Period is ending.
- * You are Disabled and in addition:
 - (1) You are unable to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance due to loss of functional capacity as a result of Sickness or Injury; or
 - (2) You require Substantial Supervision for your health or safety due to Severe Cognitive Impairment as a result of Sickness or Injury.

The condition in (1) or (2) above is expected to last [**Variable; [Variable; 30 to 730 days] or more as –or- your lifetime]** certified by a Physician Or Practitioner in the appropriate specialty as determined by the Company.

[Optional;

- * You have been continuously Disabled for at least [**Variable; 1 to 120 months.]]**

Effect Of Lifetime Security Benefit On Other Provisions Of The Group Policy

If your LTD Benefits are continued beyond the end of the Maximum Benefit Period by the Lifetime Security Benefit, the following will apply:

[Optional;

- * Your Other Income will not include any [**Optional; disability or retirement]** benefits that first become payable after the end of the Maximum Benefit Period except for those benefits that are reasonably considered by us to be a replacement for an item of Other Income that you received before the end of the Maximum Benefit Period.]

[Optional;

- * Your LTD Benefits will no longer be increased by the Indexing Factor.]

[Optional;

- * No Assisted Living Benefits will be paid.]

[Optional;

- * No Survivor Benefit will be paid if you die.]

[Optional;

- * No Employer Income Protection Benefit will be paid.]

[Optional;

- * No Medical Expense Benefit will be paid.]

[Optional;

- * No [Variable; Monthly Retirement Contribution Benefit] will be paid.]

[Optional;

- * No Annuity Contribution Benefit will be paid.]

Except as provided above, the terms of the Policy will continue to apply to your Disability as before.

When LTD Benefits End Under The Lifetime Security Benefit. LTD Benefits continued by the Lifetime Security Benefit will end automatically on the earlier of:

- * The date you no longer meet the requirements listed above.

[Optional;

- * The date LTD Benefits have been continued beyond the Maximum Benefit Period for [Variable; 1 to 40] years.]

[Optional;

- * The date LTD Benefits end under the terms of the Policy for any reason other than reaching the end of the Maximum Benefit Period.]

- b. The **Maximum Benefit Period** definition located in **2.2 BENEFIT TERMS**, is amended to add the following highlighted optional language:

Maximum Benefit Period. This is the longest period for which benefits are payable for any one period of continuous Disability, whether from one or more causes. It begins on the Beginning Date. No benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled [Optional; unless LTD Benefits are continued by the Lifetime Security Benefit]. See **Specifications [Optional; and Lifetime Security Benefit]**.

- c. The second item in **2.10 WHEN BENEFITS END**, is amended to add the following highlighted optional language:

- * The date your Maximum Benefit Period ends [Optional; unless LTD Benefits are continued by the Lifetime Security Benefit. See **Lifetime Security Benefit**].

- d. The first item in **3.5 EXTENDED DISABILITY**, is amended to add the following highlighted optional language:

- * LTD Benefits will not continue beyond the end of the original Maximum Benefit Period [Optional; unless LTD Benefits are continued by the Lifetime Security Benefit. See **Lifetime Security Benefit**]; and

- e. The Assisted Living Benefit, as set forth below, will be the second optional benefit included in **ADDITIONAL BENEFITS FOR THE SEVERELY DISABLED**. To add the Assisted Living Benefit the Group Policy is amended as follows:

[Optional;

Assisted Living Benefit. If you [Optional; or your Spouse] meet the requirements below, you will be paid Assisted Living Benefits [Optional and variable; once in your lifetime –or- once

in the lifetime of you or your Spouse] according to the terms of the Policy after the Company receives satisfactory Proof Of Loss.

Requirements for Member Assisted Living Benefit:

- * You are Disabled and LTD Benefits are payable [**Optional**; to you].
- * While you are Disabled:
 - (1) You, due to loss of functional capacity as a result of Sickness or Injury, become unable to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance; or
 - (2) You require Substantial Supervision for your health or safety [**Optional**; or the safety of others] due to Severe Cognitive Impairment as a result of Sickness or Injury.

[Optional;

- * The condition in (1) or (2) above is expected to last [**Variable**; [**Variable**; 30 to 730 days] or more—**or**— your lifetime] as certified by a Physician Or Practitioner in the appropriate specialty as determined by the Company.]

[Optional;

- * You have been continuously Disabled for at least [**Variable**; 1 to 120 months].]

[Optional;

- * You have not received [**Variable**; Assisted Living Benefits] under the Policy before.]

[Optional;

Requirements For Spouse Assisted Living Benefit. While insured under the Policy [**Optional**; and under [**Variable**; age 65 —**or**— the age specified in the Spouse's Maximum Benefit Period]]:

- (1) Your Spouse, due to loss of functional capacity as a result of Sickness or Injury, becomes unable to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance; or
- (2) Your Spouse requires Substantial Supervision for his or her safety [**Optional**; or the safety of others] due to Severe Cognitive Impairment as a result of Sickness or Injury.

[Optional;

- * The condition in (1) or (2) is expected to last [**Variable**; 30 to 730 days or more —**or**— your Spouse's lifetime], as certified by a Physician Or Practitioner in the appropriate specialty as determined by The Company.]

[Optional;

- * Your Spouse has not received Assisted Living Benefits under the Policy before.]]

[Optional;

Amount Of The Assisted Living Benefit. The Assisted Living Benefit amount is shown in the Specifications.]

[Optional;

- * The Assisted Living Benefit amount will be adjusted annually by the same Indexing factor used to adjust your LTD Benefit.]

Becoming Insured For Assisted Living Benefits. You **[Optional;** and your Spouse] are eligible for Assisted Living Benefit coverage if you are insured for LTD insurance.

[Optional;

- * You are eligible to insure your Spouse for Assisted Living Benefit coverage if you are insured for Assisted Living Benefit Coverage.]

[Optional;

- * Note; A Spouse who is a member of the armed forces of any country may not be insured. A Member may not be insured for Assisted Living Benefits as both a Member and a Spouse.]

Effective Date of Assisted Living Benefit Coverage. Subject to the **Active Work Requirement** **[Optional;** and the Hospital **[Optional;** or Nursing Home] confinement provision], your Assisted Living Benefit coverage becomes effective as follows:

[Optional;

- * Assisted Living Benefit Coverage Subject to Evidence Of Insurability. Assisted Living Benefit coverage subject to Evidence Of Insurability becomes effective on **[Optional;** the first day of the calendar month coinciding with or next following] the date the Company approves your Evidence Of Insurability, but not before the date your LTD insurance becomes effective.]

[Optional;

- * Assisted Living Benefit Coverage Subject to Evidence Of Insurability. Assisted Living Benefit coverage subject to Evidence Of Insurability becomes effective on the later of the dates below, but not before the date your LTD Insurance becomes effective.
 - (1) For you, **[Optional;** the first day of the calendar month coinciding with or next following] the date we approve your Evidence Of Insurability; and
 - (2) For your Spouse, **[Optional;** the first day of the calendar month coinciding with or next following] the date we approve Evidence Of Insurability for your Spouse.]

* Assisted Living Benefit Coverage Not Subject To Evidence Of Insurability. The **Specifications** state whether Assisted Living Benefit coverage is Contributory or Noncontributory.

* Noncontributory coverage not subject to Evidence Of Insurability becomes effective on the following dates:

[Optional;

(1) For you, on the date your LTD insurance becomes effective.]

[Optional;

(2) For your Spouse, on the later of the date your LTD insurance is effective and the date you acquire a Spouse.]

* You must apply in writing for Contributory coverage and agree to pay premiums. Contributory coverage not subject to Evidence Of Insurability becomes effective on the latest of:

[Optional;

(1) For you **[Optional;** or your Spouse], the date your LTD insurance becomes effective if you apply on or before that date.]

[Optional;

(2) For your Spouse, the date you become eligible to insure your Spouse if you apply on or before that date.]

[Optional;

(3) For you **[Optional;** or your Spouse], the date you apply if you apply within **[Variable; 0 to 31]** days after you become eligible.]

Late application: Evidence Of Insurability is required if you apply more than **[Variable; 31 to 60 days]** after you **[Optional;** or your Spouse] become eligible.

[Optional;

Hospital [Optional; or Nursing Home] Confinement Provision. Assisted Living Benefit coverage for your Spouse will not become effective on the scheduled effective date if your Spouse is confined to a Hospital **[Optional;** or Nursing Home] on the day before that date. Assisted Living Benefit coverage for your Spouse will become effective on the day after the Hospital **[Optional;** or Nursing Home] confinement ends, if on that date your Spouse is performing in the customary manner all the normal activities of a person in good health of the same age and gender.]

Payment Of Assisted Living Benefits. The Company will pay Assisted Living Benefits] within 30 days after Proof Of Loss is satisfied. Your Assisted Living Benefits will be paid to you at the same time LTD Benefits are payable. **[Optional;** Assisted Living Benefits for your Spouse will be paid to you at the end of each month that your Spouse qualifies for them.] **[Optional;** If you lack legal capacity, Assisted Living Benefits will be paid at the Company's option to your

legal representative.] **[Optional;** If you lack legal capacity, Assisted Living Benefits will be paid at the Company's option to the legal representative for you or your Spouse.]

[Optional;

When Assisted Living Benefits End. Your Assisted Living Benefits end automatically on the earliest of:

- * The date you no longer meet the Assisted Living Benefits requirements.
- * The date your LTD Benefits end.

[Optional;

When Assisted Living Benefits for your Spouse End. Assisted Living Benefits for your Spouse end automatically on the earliest of:

- * The date your Spouse no longer meets the Assisted Living Benefits requirements.
- * The date your Spouse's Maximum Benefit Period ends; and
- * The date your Spouse dies.]]

[Optional;

Waiver of Premium for [Variable; Assisted Living Benefit]. Payment of premium for Assisted Living Benefit coverage is waived while LTD Benefits are payable.]

[Optional;

When Assisted Living Benefit Coverage Ends. [Variable; Your Assisted Living Benefit coverage –or- Assisted Living Benefit coverage for you or your Spouse] ends automatically on the earliest of:

[Optional;

- * The date your LTD insurance ends.]
- * The date the last period ends for which a premium contribution was made for Assisted Living Benefit coverage.

[Optional;

- * For your Spouse, the date of your divorce.]
- * The date **[Optional;** the Policy terminates or] your Employer's coverage under the Policy terminates.
- * The date Assisted Living Benefit coverage terminates under the Policy.]]

[Optional;

Assisted Living Benefits After Insurance Ends Or Is Changed. The right to receive Assisted Living Benefits will not be affected by the occurrence of an event described in item below that becomes effective after you become Disabled **[Optional;** or, with respect to your Spouse, after Assisted Living Benefits become payable for him or her].

- * Termination or amendment of the Policy **[Optional;** or your Employer's coverage under the Policy].
- * Termination of Assisted Living Benefit coverage for you **[Optional;** or your Spouse] while the Policy **[Optional;** or your Employer's coverage under the Policy] remains in force.]]

[Optional;

Time Limits On Filing Proof Of Loss.

[Optional;

Proof Of Loss for the Lifetime Security Benefit must be provided within 90 days after the date the Maximum Benefit Period ends. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.]

[Optional;

Proof Of Loss for the Assisted Living Benefit must be provided within 90 days after the date the inability to perform Activities Of Daily Living or the Severe Cognitive Impairment begins. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.]

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.]

[Optional;

Conversion. **[Optional;** Neither] **[Optional;** the Assisted Living Benefit] **[Optional and Variable;** nor –or- and] **[Optional;** the Lifetime Security Benefit] coverage may **[Optional;** not] be converted under the Conversion Of Insurance provision.]

[Optional;

[Optional; Assisted Living Benefit] [Optional; And] [Optional; Lifetime Security Benefit] Exclusions and Limitations.

[Optional;

[Optional; No Assisted Living Benefit will be paid] **[Optional;** and] **[Optional;** LTD Benefits will not be continued by the Lifetime Security Benefit] for any period when you are confined for any reason in a penal or correctional institution.]

[Optional;

[Optional; No Assisted Living Benefit will be paid] **[Optional;** and] **[Optional;** LTD Benefits will not be continued by the Lifetime Security Benefit] if the inability to perform Activities Of Daily Living or the Severe Cognitive Impairment is caused or contributed to by:

[Optional;

- * War or any act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between the organizational forces of a military nature.]

[Optional;

- * Any intentionally self-inflicted Injury, while sane or insane.]

[Optional;

- * Substance Abuse or Dependency. This includes drug abuse, alcohol abuse or chemical dependency.]

[Optional;

- * A Mental Disorder.]

[Optional;

- * Committing or attempting to commit an assault or felony, or active participation in a violent disorder or riot. (Active participation does not include being at the scene of a violent disorder or riot while performing official duties.))]

[Optional;

- * A Preexisting Condition. For the purposes of the **[Optional; Assisted Living Benefit]** **[Optional; and]** **[Optional; Lifetime Security Benefit]**, Preexisting Condition means a mental or physical condition for which you **[Optional; or your Spouse]** have **[Variable; consulted a Physician Or Practitioner]**, received medical treatment or services, or taken prescribed drugs or medications at any time during the **[Variable; 3 to 24 months]** just before your **[Optional; Assisted Living Benefit]** **[Optional; or your Spouse's Assisted Living Benefit coverage]** is effective.

Period Of Exclusion. This exclusion will not apply after the **[Optional; Assisted Living Benefit]** **[Optional; and]** **[Optional; Lifetime Security Benefit]** coverage has been continuously in effect for a period of **[Variable; 12 to 24 months]**, if after that period:

- * You have been Actively At Work for at least **[Variable; one full day]**.
[Optional; or]
- * with respect to your Spouse, he or she has been performing in the customary manner all the normal activities of a person in good health of the same age and gender for at least **[Variable; one full day]**.]

Definitions for [Optional; Assisted Living Benefit] [Optional; and] [Optional; Lifetime Security Benefit].

Activities Of Daily Living. This means **[Optional; Ambulating,]** Bathing, Continence, Dressing, Eating, Toileting, or Transferring.

[Optional;

Ambulating. Ambulating means walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.]

Bathing. This means washing oneself, whether in the tub or shower or by sponge bath, with or without the help of adaptive devices.

Continence. This means voluntarily controlling bowel and bladder function, or, if incontinent, maintaining a reasonable level of personal hygiene.

Dressing. This means putting on and removing all items of clothing, footwear, and medically

Eating. This means getting food and fluid into the body, whether manually, intravenously, or by feeding tube.

Toileting. This means getting to and from and on and off the toilet, and performing related personal hygiene.

Transferring. This means moving into or out of a bed, chair or wheelchair, with or without adaptive devices.

Hands-on Assistance. This means the physical assistance of another person without which the insured would be unable to perform the Activity Of Daily Living.

Standby Assistance. This means the presence of another person within arm's reach of the insured that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing the Activity Of Daily Living (such as being ready to catch the insured if the insured falls while getting into or out of the bathtub or shower as part of Bathing, or being ready to remove food from the insured throat if the insured chokes while Eating).

Severe Cognitive Impairment. This is a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) is measured by clinical evidence and standardized tests approved by us that reliably measure impairment in (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning. Severe Cognitive Impairment does not include loss or deterioration as a result of a Mental Disorder.

Substantial Supervision. This means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (such as may result from wandering).

- f. In the **SPECIFICATIONS** section, **SECTION 2. BENEFITS** is also amended to add the following language:

[Optional;

[Variable; 2.17] ASSISTED LIVING BENEFIT

Amount:

[Variable; An additional [Variable; 5 to 100]% of the first \$[Variable; 1 to 33,250] of your [Optional; Indexed] Predisability Earnings [Optional; [Variable; unreduced by any Other Income (not used to reduce your LTD Benefit)].]

9. In order to add a **MONTHLY RETIREMENT CONTRIBUTION BENEFIT**, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language

[Optional;

[Variable; 2.18] [Variable; MONTHLY RETIREMENT CONTRIBUTION BENEFIT]

If you meet all of the requirements below the Company will pay a **[Variable; Monthly Retirement Contribution Benefit]** according to the terms of the Policy after the Company receives Proof Of Loss satisfactory to the Company.

Requirements For **[Variable; The Monthly Retirement Contribution Benefit]:**

- * You are participating in your Employer's **[Variable; 403(b) retirement plan –or- retirement plan –or- pension plan]** on the date of your Disability.
- * You are Disabled and **[Variable; LTD Benefits]** are payable to you.

[Optional;

- * You are entitled to Social Security disability benefits; and are receiving such benefits; or are receiving Social Security early retirement benefits or widow's or widower's benefits; or Social Security disability benefits are not payable because they are being reduced by other income you receive.

If, in the Company's sole discretion, you are not entitled to Social Security disability benefits solely because you have not earned the required minimum number of quarters for Social Security coverage, you will be considered to have met this requirement for the purposes of being eligible for this benefit.]

[Variable; Monthly Retirement Contribution Benefit] Amount. The amount of the **[Variable; Monthly Retirement Contribution Benefit]** will be the smallest of:

[Optional;

- * **[Variable; ranges from 1 to 25% of the first \$[Variable; ranges from 1 to 25,000] of your Predisability Earnings, but not to exceed] \$[Variable; ranges from 1 to 25,000];]**

[Optional;

- * The amount your Employer's retirement plan may accept according to the retirement plan's definition of compensation for you;]

[Optional;

- * The monthly average amount your Employer contributed to your Employer's retirement plan on your behalf during the **[Variable; 12-24]** calendar months preceding the date you became Disabled.]

The **[Variable; Monthly Retirement Contribution Benefit]** is not reduced by Other Income.

Payment Of The [Variable; Monthly Retirement Contribution Benefit]. **[Variable;** The Monthly Retirement Contribution Benefit] will not be paid directly to you. **[Optional;** **[Variable;** The Monthly Retirement Contribution Benefit] will be paid to **[Variable;** the administrator of your Employer's **[Variable; 403(b) retirement plan] –or- [Variable; Teachers Insurance and Annuity Association of America and/or College Retirement Equities Fund] -or- your Employer]** as **[Variable; premiums remitted –or- contributions]** on your behalf under the terms of your Employer's retirement plan.] **[Optional;** **[Variable;** The Monthly Retirement Contribution Benefit] will be paid to fund your future pension benefits from your Employer's pension plan, as determined by your Employer.]

[Optional;

The United States Internal Revenue Code limits the annual contributions for you under your Employer's retirement plan. The Company can pay **[Variable; the Monthly Retirement Contribution Benefit]** only to the extent of those annual limits.]

The Company will pay **[Variable; the Monthly Retirement Contribution Benefit]** within 30 days after Proof Of Loss is satisfied. **[Optional; Your [Variable; Monthly Retirement Contribution Benefit] will be paid at the same time [Variable; LTD Benefits] are payable.]**

[Optional;

[Variable; The Monthly Retirement Contribution Benefit] will first be applied to reduce any overpayment of your claim.]

When [Variable; The Monthly Retirement Contribution] Ends. **[Variable; Monthly Retirement Contribution Benefits]** end automatically on the earliest of:

- * The date your **[Variable; LTD Benefits]** end.
- * **[Variable; The date you withdraw any funds from any retirement plan the Company contributed to for you under this Policy –or- The date you (a) begin withdrawing a monthly benefit or annuity, (b) withdraw contributions and/or interest, or (c) are required to withdraw or take a distribution of contributions and/or interest, from your Employer's retirement plan].**

[Optional;

- * The date your Employer's retirement plan or the trust is no longer able to accept the Monthly Retirement Contribution Benefit.]

[Optional;

- * The date continued contributions may cause your Employer's retirement plan to be disqualified.]

[Optional;

- * The date your employment is terminated by you or your Employer, unless your Employer's retirement plan document allows continued contributions on your behalf after such date.]

[Optional;

- * The date you begin employment with another employer or are self employed, or return to work for your Employer.]

[Optional;

Time Limits On Filing Proof Of Loss. Proof Of Loss for **[Variable; the Monthly Retirement Contribution Benefit]** must be provided within 90 days after the date you meet all the requirements shown in **[Variable; the Monthly Retirement Contribution Benefit]** Requirements above. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.]

[Optional;

Conversion of [Variable; Monthly Retirement Contribution Benefit] coverage. The [Variable; Monthly Retirement Contribution Benefit] coverage may **[Optional; not]** be converted under the Conversion Of Insurance provision.]]

- b. In the **Specifications** section, **SECTION 2. BENEFITS** is also amended to add the following language:

[Optional;

[Variable; 2.18] [Variable; MONTHLY RETIREMENT CONTRIBUTION BENEFIT]

Amount:

The smallest of the following:

[Optional;

- * **[Variable;** ranges from 1 to 25% of the first \$**[Variable;** ranges from 1 to 25,000] of your Predisability Earnings, but not to exceed] \$**[Variable;** ranges from 1 to 25,000];]

[Optional;

- * The amount your Employer's retirement plan may accept according to the retirement plan's definition of compensation for you;]

[Optional;

- * The monthly average amount your Employer contributed to your Employer's retirement plan on your behalf during the 12 calendar months preceding the date you became Disabled.]]

10. In order to add an **ANNUITY CONTRIBUTION BENEFIT**, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language:

[Optional;

[Variable; 2.19] ANNUITY CONTRIBUTION BENEFIT

Annuity Contribution Benefit Requirements. If you meet all of the requirements below the Company will pay an Annuity Contribution Benefit according to the terms of the Policy after the Company receives Proof Of Loss satisfactory to the Company.

Requirements For The Annuity Contribution Benefit:

[Optional;

- * You are **[Optional; not]** participating in your Employer's **[Variable; 403(b)]** retirement plan on the date of your Disability.]
- * You are Disabled and **[Variable; LTD Benefits]** **[Optional; are payable to you -or- have been payable to you for [Variable; 1-10 years].]**

[Optional;

- * You are entitled to Social Security disability benefits; and are receiving such benefits; or are receiving Social Security early retirement benefits or widow's or widower's benefits; or Social Security disability benefits are not payable because they are being reduced by other income you receive.

If, in the Company's sole discretion, you are not entitled to Social Security disability benefits solely because you have not earned the required minimum number of quarters for Social Security coverage, you will be considered to have met this requirement for the purposes of being eligible for this benefit.]

- * You submit a signed application for the annuity that the Company will purchase for you and any other information required by the annuity provider the Company selects.]

Annuity Contribution Benefit Amount. The amount of the Annuity Contribution Benefit will be **[Optional; [Variable; 1 to 25]%** of the first **[\$[Variable;1 to 25,000]** of your Predisability Earnings, but not to exceed **[Optional; \$[Variable; 50 to 15,000]]**. The Annuity Contribution Benefit is not reduced by Other Income. **[Optional; The minimum Annuity Contribution Benefit payable will be \$[Variable; 25 to 500].**

[Optional;

If the Annuity Contribution Benefit is includable in your gross income for federal income tax purposes, the Company will increase your Maximum Benefit percentage by **[Variable;1 to 10]** percentage points while the Annuity Contribution Benefit is payable. For example, if your Maximum Benefit percentage is **[Variable; 60%]**, as shown in the **Specifications**, it will be increased to **[Variable; 61%]**. This change will be effective when the Annuity Contribution Benefit becomes payable and will not be retroactive to any time period prior to the Annuity Contribution Benefit being payable.]

Payment Of The Annuity Contribution Benefit. The Company will purchase an annuity for you from a company and of a type the Company determines using the Company's sole discretion. The Annuity Contribution Benefit will be paid as premiums into this annuity. The Annuity Contribution Benefit will not be paid directly to you.

However, if the Company determines that the Annuity Contribution Benefit is likely to only be paid for **[Variable; 12 to 60]** months or less, due to the Maximum Benefit Period or some other limiting factor, or if you reside in a jurisdiction where the Company does not have a relationship with an annuity carrier doing business in that jurisdiction, then, at the Company's discretion, it will not purchase an annuity for you and the Annuity Contribution Benefit will instead be paid directly to you. In this situation you will not be required to submit a signed application form for an annuity.

The Company will pay the Annuity Contribution Benefit within 30 days after Proof Of Loss is satisfied and your signed application for the annuity is approved by the annuity carrier the Company selects. **[Optional; Your Annuity Contribution Benefit will be paid at the same time [Variable; LTD Benefits] are payable.]**

[Optional;

The Annuity Contribution Benefit will first be applied to reduce any overpayment of your claim.]

When The Annuity Contribution Benefit Ends.

Annuity Contribution Benefits **[Optional;** and any corresponding increase in your **[Variable; LTD Benefits]]** end automatically on the earliest of:

- * The date your **[Variable; LTD Benefits]** end.
- * The date you withdraw any funds from any annuity the Company contributed to for you under this Policy.

[Optional;

- * The date you execute an exchange under Section 1035 of the IRC of an annuity the Company contributed to for you under this Policy.]

[Optional;

Time Limits On Filing Proof Of Loss. Proof Of Loss for the Annuity Contribution Benefit must be provided within 90 days after the date you meet all the requirements shown in the Annuity Contribution Benefit Requirements above. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.]

[Optional;

Conversion of Annuity Contribution Benefit coverage. The Annuity Contribution Benefit coverage may **[Optional; not]** be converted under the Conversion Of Insurance provision.]]

- b. In the **Specifications** section, **SECTION 2. BENEFITS** is also amended to add the following language:

[Optional;


[Variable; 2.19] [Variable; MONTHLY ANNUITY CONTRIBUTION BENEFIT]

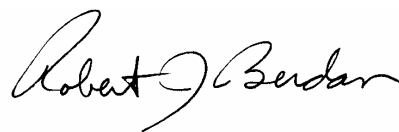
Amount:

The amount of the Annuity Contribution Benefit will be **[Optional; [Variable; 1 to 25]% of the first \$[Variable; 1 to 25,000] of your Predisability Earnings, but not to exceed [Optional; \$[Variable; 50 to 15,000]].** The Annuity Contribution Benefit is not reduced by Other Income. **[Optional; The minimum Annuity Contribution Benefit payable will be \$[Variable; 25 to 500].]**

The Northwestern Mutual Life Insurance Company

By


President and C.E.O.


Secretary

ATTACHMENT TO GROUP LONG TERM DISABILITY INSURANCE CERTIFICATE FORM

Attached to and made a part of Group Certificate Form MN 992-LTDC

Group Certificate Form MN 992-LTDC is amended to update policy language, and include the following provisions for any Policyowner who negotiates inclusion of such language into its Long Term Disability policy issued by us. The use of brackets ([]) indicate the language is optional or variable; optional language is either included or removed in entirety, while variable language shows possible language choices or the most common number range used within the brackets.

1. In order to provide a definition of Spouse, **SECTION 2.2 BENEFIT TERMS** is amended as follows:

[Optional;

[Variable;

Spouse. Spouse is defined as follows:

- * A person to whom you are legally married; or
- * Your Domestic Partner. Your Domestic Partner means an individual recognized as such under applicable law.

-or-

- * A person to whom you are legally married; or
- * Your Domestic Partner. Domestic Partner means an individual with whom you have completed an affidavit of declaration of domestic partnership, submitted that affidavit to the Employer, and filed that affidavit for public record if required by law; or an individual recognized as your Domestic Partner under applicable law.]]

2. In order to provide an Own Specialty Definition of Disability for dentists, the Own Occupation Definition of Disability located in **SECTION 2.3 DEFINITION OF DISABILITY**, is amended to add the following language:

[Optional;

However, if your Own Occupation is **[Variable; dentist]**, during the period preceding your Beginning Date and throughout **[Optional; the first [Variable; ranges from 12 to 60] months of]** the Own Occupation Period, the Company will consider your Own Occupation to be the **[Optional and Variable; ranges from one to five] [Variable; dental] [Variable; specialty/specialties]** in which you are board certified to practice **[Optional; for which there is a specialty recognized by the [Variable: American Dental Association],]** provided you have earned at least **[Variable; ranges from 50 to 90]%** of your gross professional service fee income in your **[Variable; specialty/specialties]** during the **[Variable; ranges from 24 to 48] months** immediately before you become Disabled.]

3. In order to provide working claimants a benefit of the greater of certain amounts, the Group Policy is amended as follows:

- a. **SECTION 2.5 BENEFIT AMOUNTS**, is amended to include the following optional language

[Optional;

If you have Work Earnings, the Company will pay the greater of the following benefits:]

[Optional:

However, if you have at least an 80% Loss of Earnings, the Proportionate Benefit amount will be 100% of the LTD Benefit. In no event will the amount payable be more than 100% of the LTD Benefit.]

- b. In the **SPECIFICATIONS** section, item **2.5 BENEFIT AMOUNTS**, is also amended to include the following language:

[Optional;

If you have Work Earnings, the Company will pay the greater of the following benefits:]

[Optional:

If you have at least an 80% Loss of Earnings, the Proportionate Benefit amount will be 100% of the LTD Benefit.]

4. In order to provide an Employer Income Protection Benefit, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language

[Optional;

[Variable; 2.13] EMPLOYER INCOME PROTECTION BENEFIT

Insuring Clause. **[Optional;** During the period preceding the Beginning Date and] while **[Variable; LTD Benefits]** are payable to a **[Variable; Member –or- Key Person]**, an Employer Income Protection (EIP) Benefit will be paid to the **[Variable; Member’s –or- Key Person’s]** Employer according to the terms of the Policy.

Key Person. Key person means a **[Variable; President, Sr. Vice President, Key Producer]**.

Schedule. The EIP Benefit Period is **[Variable; 6 to 24]** months or the period **[Variable; LTD Benefits]** are payable, whichever is shorter.

Employer Income Protection Amount. The amount of the EIP Benefit is:

Formula 1; **[Variable; 10 to 100]**% of the **[Variable; Member’s –or- Key Person’s]** Indexed Predisability Earnings, subject to the **[Variable; Maximum Benefit]**. See Specifications.

However, if the **[Variable; Member’s –or- Key Person’s]** Work Earnings exceed **[Variable; 10 to 50]**% of the **[Variable; Member's –or- Key Person's]** Indexed Predisability Earnings, the following Formula 2 will be used to determine the amount of the EIP Benefit.

Formula 2; (A divided by B) times C, where:

A = The **[Variable; Member’s –or- Key Person’s]** Indexed Predisability Earnings, minus the **[Variable; Member’s –or- Key Person’s]** Work Earnings.

B = The **[Variable; Member’s –or- Key Person’s]** Indexed Predisability Earnings.

C = The amount determined in Formula 1.

The EIP Benefit will **[Optional; not]** be reduced by Deductible Income.

When EIP Benefits End. EIP Benefits end automatically on the earliest of:

- * The date the EIP Benefit Period Ends.
- * The date the Employer ceases to employ the [Variable; Member –or- Key Person].
- * The date the [Variable; Member –or- Key Person] becomes employed by another employer.
- * The date the Policy terminates.]

- b. In the **SPECIFICATIONS** section, **SECTION 2. BENEFITS** is also amended to include the following language:

[Optional;

[Variable; 2.13] EMPLOYER INCOME PROTECTION BENEFIT

Formula 1:

[Variable; 10 to 100]% of the [Variable; Member's –or- Key Person's] Indexed Predisability Earnings, subject to the Maximum Benefit.

However, if the **[Variable; Member's –or- Key Person's] Work Earnings** exceed **[Variable; 10 to 50]% of the [Variable; Member's –or- Key Person's] Indexed Predisability Earnings**, the following Formula 2 will be used to determine the amount of the EIP Benefit.

Formula 2: (A divided by B) times C, where:

A = The **[Variable; Member's –or- Key Person's] Indexed Predisability Earnings**, minus the **[Variable; Member's –or- Key Person's] Work Earnings**.

B = The **[Variable; Member's –or- Key Person's] Indexed Predisability Earnings**.

C = The amount determined in Formula 1.

5. In order to add an optional **SPECIAL DISMEMBERMENT PROVISION**, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language:

[Optional;

[Variable; 2.14] SPECIAL DISMEMBERMENT PROVISION

If you suffer a Loss as a result of an accident **[Optional; or exposure to the natural elements]**, you will be considered Disabled for the applicable Minimum Benefit Period **[Variable; subject to the Maximum Benefit Period –or- even if this causes [Variable: LTD Benefits] to be payable beyond the end of the Maximum Benefit Period]**.

Definition Of Loss. Loss means loss of hand, foot, or sight **[Optional; , speech or hearing, [Optional; or thumb and index finger of the same hand] which:**

- * Is caused solely and directly by an accident **[Optional; or exposure to the natural elements];**
- * Occurs independently of all other causes;

- * Occurs within 90 days after the accident;
- * Occurs while you are insured under the Policy **[Optional; , unless the Policy terminates after the date of the accident and you are continuously Disabled from the date the Policy terminates to the date of the Loss].**

With respect to a hand or foot, Loss means actual and permanent severance from the body at or above the wrist or ankle joint.

With respect to sight, Loss means entire and irrecoverable loss of sight.

[Optional;

With respect to speech or hearing, Loss means entire and irrecoverable loss of audible speech or hearing, as certified by a Diplomate of the American Board of Otolaryngology.]

[Optional;

With respect to thumb and index finger of the same hand, Loss means actual and permanent severance from the body at or above the metacarpophalangeal joints.]

Minimum Benefit Period. The Minimum Benefit Period for a Loss of one hand, one foot, or sight of one eye, **[Optional; or speech or hearing,] [Optional; or thumb and index finger of the same hand]** is **[Variable; 1 to 12] months [Optional; or to the end of the Maximum Benefit Period, whichever is shorter].** The Minimum Benefit Period for two or more of the above Losses is **[Variable; 2 to 24] months [Optional; or to the end of the Maximum Benefit Period, whichever is shorter].**

You will not be considered Disabled for more than the longer Minimum Benefit Period described above with respect to all Losses from the same accident **[Optional; or exposure to the natural elements].**

The Minimum Benefit Period begins **[Variable; on the Beginning Date –or- on the date of the Loss].** The Minimum Benefit Period counts as part of the Maximum Benefit Period.

[Optional;

During the Minimum Benefit Period your **[Variable; LTD Benefit]** will not be reduced by sick pay or other salary continuation paid to you by your Employer or by your Work Earnings.]

Exclusions. No **[Variable; LTD Benefit]** is payable under this provision if the Loss is caused or contributed to by any of the exclusions listed in the section entitled **Exclusions and Limitations [Optional; or any of the following]:**

[Optional;

- * War or act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.]

[Optional;

- * Attempted suicide or other intentionally self-inflicted injury, while sane or insane.]

[Optional;

- * Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.]

[Optional;

- * The voluntary use or consumption of any poison, chemical compound or drug, unless used or consumed according to the directions of a physician.]

[Optional;

- * Sickness, Injury, or Pregnancy existing at the time of the accident.]

[Optional;

- * Heart attack or stroke.]

[Optional;

- * The use or consumption of alcohol or your alcoholism.]

[Optional;

- * Medical or surgical treatment for any of the above.]]

- b. In the **SPECIFICATIONS** section, **SECTION 2. BENEFITS** is also amended to add the following language:

[Optional;

[Variable; 2.14] [Variable; SPECIAL DISMEMBERMENT PROVISION]

Loss of one hand, one foot, or sight of one eye **[Optional;** or period, speech or hearing,] **[Optional;** or thumb and index finger of the same hand]:

Minimum Benefit Period is **[Variable; 1 to 12]** months **[Optional;** or to the end of the Maximum Benefit whichever is shorter].

Loss of two or more of the above:

Minimum Benefit Period is **[Variable; 2 to 24]** months **[Optional;** or to the end of the Maximum Benefit Period, whichever is shorter].]

6. In order to add a **MEDICAL EXPENSE BENEFIT**, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language:

[Optional;

[Variable; 2.15] MEDICAL EXPENSE BENEFIT. The Company will pay a Medical Expense Benefit to you according to the rules below:

- * **[Variable;** LTD Benefits are payable to you **–or–** You are receiving LTD Benefits] **[Optional;** and you have been continuously Disabled for at least **[Variable; 1-365 days].**

- * The amount of the Medical Expense Benefit is [Variable; [Variable; \$50 to 20,000 -or- [Variable; 10 to 80% of your [Variable; Predisability Earnings -or- LTD Benefit]] [Variable; per month -or- in a lump sum] [Variable; or the actual monthly amount of your medical premiums you pay for yourself [Optional; and your family] if less].
- * The Medical Expense Benefit is payable [Variable; for a maximum of [Variable; 1 to 60] months -or- to the end of the Maximum Benefit Period] [Variable; for each period of Disability -or- once in your entire lifetime].

[Optional;

- * The Medical Expense Benefit amount will be first applied to reduce any overpayment of your claim.]

[Optional;

- * The Medical Expense Benefit amount will be adjusted in conjunction with the [Variable; LTD Benefit] by the same Indexing Factor used to adjust your [Variable; LTD Benefit]. See **Indexed Income Benefit.**

[Optional;

- * Medical Expense Coverage may [Optional; not] be continued under the **Conversion of Insurance** provision.]]

- b. In the **SPECIFICATIONS** section, **SECTION 2. BENEFITS** is also amended to add the following language:

[Optional;

[Variable; 2.15] **MEDICAL EXPENSE BENEFIT**

Amount: The amount of [Variable; the Medical Expense Benefit] is [Variable; [Variable; \$50 to 20,000 -or- [Variable; 10 to 80% of your [Variable; Predisability Earnings -or- LTD Benefit]] [Variable; per month -or- in a lump sum] [Variable; or the actual monthly amount of your medical premiums you pay for yourself [Optional; and your family] if less].]

7. In order to add a **FAMILY CARE EXPENSES ADJUSTMENT** provision, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language:

[Optional;

[Variable; 2.16] **FAMILY CARE EXPENSES ADJUSTMENT.** If you must pay Family Care Expenses in order to work, the Company will reduce the amount of the Work Earnings used in determining your Loss Of Earnings, subject to the following:

- * Your Work Earnings will be reduced by the first \$[Variable; 250] per Family Member of the monthly Family Care Expenses you pay, but not to exceed a total of \$[Variable; 500] for all Family Members.
- * The Work Earnings and the Family Care Expenses must be for the same period.

- * You must give the Company satisfactory proof of the Family Care Expenses you pay.
- * The Work Earnings reduction by Family Care Expenses will end [**Variable; 12 months**] after it begins.

Family Care Expenses. This is the amount you pay to a licensed care provider for the care of your Family Member which is necessary in order for you to work.

Family Member. This includes:

- * Your Child; or
- * Your Spouse, parent, grandparent, sibling, or other close family member residing in your home who is;
 - (1) Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
 - (2) Chiefly dependent upon you for support and maintenance.

Child. This includes:

- * Your child residing in your home (including your stepchild an adopted child), from live birth through age [**Variable; 11**]; or
- * Your child, age [**Variable; 12**] or older, residing in your home (including your stepchild and an adopted child) who is;
 - (1) Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
 - (2) Chiefly dependent upon you for support and maintenance.]

- b. In the **Specifications** section, **SECTION 2. BENEFITS** is also amended to add the following language:

[**Optional;**

[**Variable; 2.16**] **FAMILY CARE EXPENSES ADJUSTMENT** [**Variable; Yes –or- No**]

8. In order to add an **ADDITIONAL BENEFITS FOR THE SEVERELY DISABLED** provision, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language:

[**Optional;**

[**Variable; 2.17**] **ADDITIONAL BENEFITS FOR THE SEVERELY DISABLED**

[**Optional;**

Lifetime Security Benefit. If you meet the requirements below on the date your Maximum Benefit Period ends, LTD Benefits will be payable beyond the end of your Maximum Benefit Period [**Optional; for an additional [Variable; 1 to 40 years]**, according to the terms of the Policy after the Company receives satisfactory Proof Of Loss.]

Requirements For Lifetime Security Benefit:

- * Benefits are scheduled to end solely because your Maximum Benefit Period is ending.
- * You are Disabled and in addition:
 - (1) You are unable to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance due to loss of functional capacity as a result of Sickness or Injury; or
 - (2) You require Substantial Supervision for your health or safety due to Severe Cognitive Impairment as a result of Sickness or Injury.

The condition in (1) or (2) above is expected to last [**Variable; [Variable; 30 to 730 days] or more as –or- your lifetime]** certified by a Physician Or Practitioner in the appropriate specialty as determined by the Company.

[Optional;

- * You have been continuously Disabled for at least [**Variable; 1 to 120 months.]]**

Effect Of Lifetime Security Benefit On Other Provisions Of The Group Policy

If your LTD Benefits are continued beyond the end of the Maximum Benefit Period by the Lifetime Security Benefit, the following will apply:

[Optional;

- * Your Other Income will not include any [**Optional; disability or retirement]** benefits that first become payable after the end of the Maximum Benefit Period except for those benefits that are reasonably considered by us to be a replacement for an item of Other Income that you received before the end of the Maximum Benefit Period.]

[Optional;

- * Your LTD Benefits will no longer be increased by the Indexing Factor.]

[Optional;

- * No Assisted Living Benefits will be paid.]

[Optional;

- * No Survivor Benefit will be paid if you die.]

[Optional;

- * No Employer Income Protection Benefit will be paid.]

[Optional;

- * No Medical Expense Benefit will be paid.]

[Optional;

- * No [Variable; Monthly Retirement Contribution Benefit] will be paid.]

[Optional;

- * No Annuity Contribution Benefit will be paid.]

Except as provided above, the terms of the Policy will continue to apply to your Disability as before.

When LTD Benefits End Under The Lifetime Security Benefit. LTD Benefits continued by the Lifetime Security Benefit will end automatically on the earlier of:

- * The date you no longer meet the requirements listed above.

[Optional;

- * The date LTD Benefits have been continued beyond the Maximum Benefit Period for [Variable; 1 to 40] years.]

[Optional;

- * The date LTD Benefits end under the terms of the Policy for any reason other than reaching the end of the Maximum Benefit Period.]

- b. The **Maximum Benefit Period** definition located in **2.2 BENEFIT TERMS**, is amended to add the following highlighted optional language:

Maximum Benefit Period. This is the longest period for which benefits are payable for any one period of continuous Disability, whether from one or more causes. It begins on the Beginning Date. No benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled [Optional; unless LTD Benefits are continued by the Lifetime Security Benefit]. See **Specifications [Optional; and Lifetime Security Benefit]**.

- c. The second item in **2.10 WHEN BENEFITS END**, is amended to add the following highlighted optional language:

- * The date your Maximum Benefit Period ends [Optional; unless LTD Benefits are continued by the Lifetime Security Benefit. See **Lifetime Security Benefit**].

- d. The first item in **3.5 EXTENDED DISABILITY**, is amended to add the following highlighted optional language:

- * LTD Benefits will not continue beyond the end of the original Maximum Benefit Period [Optional; unless LTD Benefits are continued by the Lifetime Security Benefit. See **Lifetime Security Benefit**]; and

- e. The Assisted Living Benefit, as set forth below, will be the second optional benefit included in **ADDITIONAL BENEFITS FOR THE SEVERELY DISABLED**. To add the Assisted Living Benefit the Group Policy is amended as follows:

[Optional;

Assisted Living Benefit. If you [Optional; or your Spouse] meet the requirements below, you will be paid Assisted Living Benefits [Optional and variable; once in your lifetime –or- once

in the lifetime of you or your Spouse] according to the terms of the Policy after the Company receives satisfactory Proof Of Loss.

Requirements for Member Assisted Living Benefit:

- * You are Disabled and LTD Benefits are payable [**Optional**; to you].
- * While you are Disabled:
 - (1) You, due to loss of functional capacity as a result of Sickness or Injury, become unable to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance; or
 - (2) You require Substantial Supervision for your health or safety [**Optional**; or the safety of others] due to Severe Cognitive Impairment as a result of Sickness or Injury.

[Optional;

- * The condition in (1) or (2) above is expected to last [**Variable**; [**Variable**; 30 to 730 days] or more—**or**— your lifetime] as certified by a Physician Or Practitioner in the appropriate specialty as determined by the Company.]

[Optional;

- * You have been continuously Disabled for at least [**Variable**; 1 to 120 months].]

[Optional;

- * You have not received [**Variable**; Assisted Living Benefits] under the Policy before.]

[Optional;

Requirements For Spouse Assisted Living Benefit. While insured under the Policy [**Optional**; and under [**Variable**; age 65 —**or**— the age specified in the Spouse's Maximum Benefit Period]]:

- (1) Your Spouse, due to loss of functional capacity as a result of Sickness or Injury, becomes unable to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance; or
- (2) Your Spouse requires Substantial Supervision for his or her safety [**Optional**; or the safety of others] due to Severe Cognitive Impairment as a result of Sickness or Injury.

[Optional;

- * The condition in (1) or (2) is expected to last [**Variable**; 30 to 730 days or more —**or**— your Spouse's lifetime], as certified by a Physician Or Practitioner in the appropriate specialty as determined by The Company.]

[Optional;

- * Your Spouse has not received Assisted Living Benefits under the Policy before.]]

[Optional;

Amount Of The Assisted Living Benefit. The Assisted Living Benefit amount is shown in the Specifications.]

[Optional;

- * The Assisted Living Benefit amount will be adjusted annually by the same Indexing factor used to adjust your LTD Benefit.]

Becoming Insured For Assisted Living Benefits. You **[Optional;** and your Spouse] are eligible for Assisted Living Benefit coverage if you are insured for LTD insurance.

[Optional;

- * You are eligible to insure your Spouse for Assisted Living Benefit coverage if you are insured for Assisted Living Benefit Coverage.]

[Optional;

- * Note; A Spouse who is a member of the armed forces of any country may not be insured. A Member may not be insured for Assisted Living Benefits as both a Member and a Spouse.]

Effective Date of Assisted Living Benefit Coverage. Subject to the **Active Work Requirement** **[Optional;** and the Hospital **[Optional;** or Nursing Home] confinement provision], your Assisted Living Benefit coverage becomes effective as follows:

[Optional;

- * Assisted Living Benefit Coverage Subject to Evidence Of Insurability. Assisted Living Benefit coverage subject to Evidence Of Insurability becomes effective on **[Optional;** the first day of the calendar month coinciding with or next following] the date the Company approves your Evidence Of Insurability, but not before the date your LTD insurance becomes effective.]

[Optional;

- * Assisted Living Benefit Coverage Subject to Evidence Of Insurability. Assisted Living Benefit coverage subject to Evidence Of Insurability becomes effective on the later of the dates below, but not before the date your LTD Insurance becomes effective.
 - (1) For you, **[Optional;** the first day of the calendar month coinciding with or next following] the date we approve your Evidence Of Insurability; and
 - (2) For your Spouse, **[Optional;** the first day of the calendar month coinciding with or next following] the date we approve Evidence Of Insurability for your Spouse.]

- * Assisted Living Benefit Coverage Not Subject To Evidence Of Insurability. The **Specifications** state whether Assisted Living Benefit coverage is Contributory or Noncontributory.

- * Noncontributory coverage not subject to Evidence Of Insurability becomes effective on the following dates:

[Optional;

- (1) For you, on the date your LTD insurance becomes effective.]

[Optional;

- (2) For your Spouse, on the later of the date your LTD insurance is effective and the date you acquire a Spouse.]

- * You must apply in writing for Contributory coverage and agree to pay premiums. Contributory coverage not subject to Evidence Of Insurability becomes effective on the latest of:

[Optional;

- (1) For you **[Optional;** or your Spouse], the date your LTD insurance becomes effective if you apply on or before that date.]

[Optional;

- (2) For your Spouse, the date you become eligible to insure your Spouse if you apply on or before that date.]

[Optional;

- (3) For you **[Optional;** or your Spouse], the date you apply if you apply within **[Variable; 0 to 31]** days after you become eligible.]

Late application: Evidence Of Insurability is required if you apply more than **[Variable; 31 to 60 days]** after you **[Optional;** or your Spouse] become eligible.

[Optional;

Hospital [Optional; or Nursing Home] Confinement Provision. Assisted Living Benefit coverage for your Spouse will not become effective on the scheduled effective date if your Spouse is confined to a Hospital **[Optional;** or Nursing Home] on the day before that date. Assisted Living Benefit coverage for your Spouse will become effective on the day after the Hospital **[Optional;** or Nursing Home] confinement ends, if on that date your Spouse is performing in the customary manner all the normal activities of a person in good health of the same age and gender.]

Payment Of Assisted Living Benefits. The Company will pay Assisted Living Benefits] within 30 days after Proof Of Loss is satisfied. Your Assisted Living Benefits will be paid to you at the same time LTD Benefits are payable. **[Optional;** Assisted Living Benefits for your Spouse will be paid to you at the end of each month that your Spouse qualifies for them.] **[Optional;** If you lack legal capacity, Assisted Living Benefits will be paid at the Company's option to your

legal representative.] **[Optional;** If you lack legal capacity, Assisted Living Benefits will be paid at the Company's option to the legal representative for you or your Spouse.]

[Optional;

When Assisted Living Benefits End. Your Assisted Living Benefits end automatically on the earliest of:

- * The date you no longer meet the Assisted Living Benefits requirements.
- * The date your LTD Benefits end.

[Optional;

When Assisted Living Benefits for your Spouse End. Assisted Living Benefits for your Spouse end automatically on the earliest of:

- * The date your Spouse no longer meets the Assisted Living Benefits requirements.
- * The date your Spouse's Maximum Benefit Period ends; and
- * The date your Spouse dies.]]

[Optional;

Waiver of Premium for [Variable; Assisted Living Benefit]. Payment of premium for Assisted Living Benefit coverage is waived while LTD Benefits are payable.]

[Optional;

When Assisted Living Benefit Coverage Ends. [Variable; Your Assisted Living Benefit coverage –or- Assisted Living Benefit coverage for you or your Spouse] ends automatically on the earliest of:

[Optional;

- * The date your LTD insurance ends.]
- * The date the last period ends for which a premium contribution was made for Assisted Living Benefit coverage.

[Optional;

- * For your Spouse, the date of your divorce.]
- * The date **[Optional;** the Policy terminates or] your Employer's coverage under the Policy terminates.
- * The date Assisted Living Benefit coverage terminates under the Policy.]]

[Optional;

Assisted Living Benefits After Insurance Ends Or Is Changed. The right to receive Assisted Living Benefits will not be affected by the occurrence of an event described in item below that becomes effective after you become Disabled **[Optional;** or, with respect to your Spouse, after Assisted Living Benefits become payable for him or her].

- * Termination or amendment of the Policy **[Optional;** or your Employer's coverage under the Policy].
- * Termination of Assisted Living Benefit coverage for you **[Optional;** or your Spouse] while the Policy **[Optional;** or your Employer's coverage under the Policy] remains in force.]]

[Optional;

Time Limits On Filing Proof Of Loss.

[Optional;

Proof Of Loss for the Lifetime Security Benefit must be provided within 90 days after the date the Maximum Benefit Period ends. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.]

[Optional;

Proof Of Loss for the Assisted Living Benefit must be provided within 90 days after the date the inability to perform Activities Of Daily Living or the Severe Cognitive Impairment begins. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.]

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.]

[Optional;

Conversion. **[Optional;** Neither] **[Optional;** the Assisted Living Benefit] **[Optional and Variable;** nor **–or- and]** **[Optional;** the Lifetime Security Benefit] coverage may **[Optional;** not] be converted under the Conversion Of Insurance provision.]

[Optional;

[Optional; Assisted Living Benefit] [Optional; And] [Optional; Lifetime Security Benefit] Exclusions and Limitations.

[Optional;

[Optional; No Assisted Living Benefit will be paid] **[Optional;** and] **[Optional;** LTD Benefits will not be continued by the Lifetime Security Benefit] for any period when you are confined for any reason in a penal or correctional institution.]

[Optional;

[Optional; No Assisted Living Benefit will be paid] **[Optional;** and] **[Optional;** LTD Benefits will not be continued by the Lifetime Security Benefit] if the inability to perform Activities Of Daily Living or the Severe Cognitive Impairment is caused or contributed to by:

[Optional;

- * War or any act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between the organizational forces of a military nature.]

[Optional;

- * Any intentionally self-inflicted Injury, while sane or insane.]

[Optional;

- * Substance Abuse or Dependency. This includes drug abuse, alcohol abuse or chemical dependency.]

[Optional;

- * A Mental Disorder.]

[Optional;

- * Committing or attempting to commit an assault or felony, or active participation in a violent disorder or riot. (Active participation does not include being at the scene of a violent disorder or riot while performing official duties.))]

[Optional;

- * A Preexisting Condition. For the purposes of the **[Optional; Assisted Living Benefit]** **[Optional; and]** **[Optional; Lifetime Security Benefit]**, Preexisting Condition means a mental or physical condition for which you **[Optional; or your Spouse]** have **[Variable; consulted a Physician Or Practitioner]**, received medical treatment or services, or taken prescribed drugs or medications at any time during the **[Variable; 3 to 24 months]** just before your **[Optional; Assisted Living Benefit]** **[Optional; or your Spouse's Assisted Living Benefit coverage]** is effective.

Period Of Exclusion. This exclusion will not apply after the **[Optional; Assisted Living Benefit]** **[Optional; and]** **[Optional; Lifetime Security Benefit]** coverage has been continuously in effect for a period of **[Variable; 12 to 24 months]**, if after that period:

- * You have been Actively At Work for at least **[Variable; one full day]**.
[Optional; or]
- * with respect to your Spouse, he or she has been performing in the customary manner all the normal activities of a person in good health of the same age and gender for at least **[Variable; one full day]**.]

Definitions for [Optional; Assisted Living Benefit] [Optional; and] [Optional; Lifetime Security Benefit].

Activities Of Daily Living. This means **[Optional; Ambulating,]** Bathing, Continence, Dressing, Eating, Toileting, or Transferring.

[Optional;

Ambulating. Ambulating means walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.]

Bathing. This means washing oneself, whether in the tub or shower or by sponge bath, with or without the help of adaptive devices.

Continence. This means voluntarily controlling bowel and bladder function, or, if incontinent, maintaining a reasonable level of personal hygiene.

Dressing. This means putting on and removing all items of clothing, footwear, and medically

Eating. This means getting food and fluid into the body, whether manually, intravenously, or by feeding tube.

Toileting. This means getting to and from and on and off the toilet, and performing related personal hygiene.

Transferring. This means moving into or out of a bed, chair or wheelchair, with or without adaptive devices.

Hands-on Assistance. This means the physical assistance of another person without which the insured would be unable to perform the Activity Of Daily Living.

Standby Assistance. This means the presence of another person within arm's reach of the insured that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing the Activity Of Daily Living (such as being ready to catch the insured if the insured falls while getting into or out of the bathtub or shower as part of Bathing, or being ready to remove food from the insured throat if the insured chokes while Eating).

Severe Cognitive Impairment. This is a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) is measured by clinical evidence and standardized tests approved by us that reliably measure impairment in (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning. Severe Cognitive Impairment does not include loss or deterioration as a result of a Mental Disorder.

Substantial Supervision. This means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (such as may result from wandering).

- f. In the **SPECIFICATIONS** section, **SECTION 2. BENEFITS** is also amended to add the following language:

[Optional;

[Variable; 2.17] ASSISTED LIVING BENEFIT

Amount:

[Variable; An additional [Variable; 5 to 100]% of the first \$[Variable; 1 to 33,250] of your [Optional; Indexed] Predisability Earnings [Optional; [Variable; unreduced by any Other Income (not used to reduce your LTD Benefit)]].]

9. In order to add a **MONTHLY RETIREMENT CONTRIBUTION BENEFIT**, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language

[Optional;

[Variable; 2.18] [Variable; MONTHLY RETIREMENT CONTRIBUTION BENEFIT]

If you meet all of the requirements below the Company will pay a **[Variable; Monthly Retirement Contribution Benefit]** according to the terms of the Policy after the Company receives Proof Of Loss satisfactory to the Company.

Requirements For **[Variable; The Monthly Retirement Contribution Benefit]:**

- * You are participating in your Employer's **[Variable; 403(b) retirement plan –or- retirement plan –or- pension plan]** on the date of your Disability.
- * You are Disabled and **[Variable; LTD Benefits]** are payable to you.

[Optional;

- * You are entitled to Social Security disability benefits; and are receiving such benefits; or are receiving Social Security early retirement benefits or widow's or widower's benefits; or Social Security disability benefits are not payable because they are being reduced by other income you receive.

If, in the Company's sole discretion, you are not entitled to Social Security disability benefits solely because you have not earned the required minimum number of quarters for Social Security coverage, you will be considered to have met this requirement for the purposes of being eligible for this benefit.]

[Variable; Monthly Retirement Contribution Benefit] Amount. The amount of the **[Variable; Monthly Retirement Contribution Benefit]** will be the smallest of:

[Optional;

- * **[Variable; ranges from 1 to 25% of the first \$[Variable; ranges from 1 to 25,000] of your Predisability Earnings, but not to exceed] \$[Variable; ranges from 1 to 25,000];]**

[Optional;

- * The amount your Employer's retirement plan may accept according to the retirement plan's definition of compensation for you;]

[Optional;

- * The monthly average amount your Employer contributed to your Employer's retirement plan on your behalf during the **[Variable; 12-24]** calendar months preceding the date you became Disabled.]

The **[Variable; Monthly Retirement Contribution Benefit]** is not reduced by Other Income.

Payment Of The [Variable; Monthly Retirement Contribution Benefit]. **[Variable;** The Monthly Retirement Contribution Benefit] will not be paid directly to you. **[Optional; [Variable; The Monthly Retirement Contribution Benefit] will be paid to [Variable; the administrator of your Employer's [Variable; 403(b) retirement plan] –or- [Variable: Teachers Insurance and Annuity Association of America and/or College Retirement Equities Fund] -or- your Employer] as [Variable; premiums remitted –or- contributions] on your behalf under the terms of your Employer's retirement plan.] [Optional; [Variable; The Monthly Retirement Contribution Benefit] will be paid to fund your future pension benefits from your Employer's pension plan, as determined by your Employer.]**

[Optional;

The United States Internal Revenue Code limits the annual contributions for you under your Employer's retirement plan. The Company can pay **[Variable; the Monthly Retirement Contribution Benefit]** only to the extent of those annual limits.]

The Company will pay **[Variable; the Monthly Retirement Contribution Benefit]** within 30 days after Proof Of Loss is satisfied. **[Optional; Your [Variable; Monthly Retirement Contribution Benefit] will be paid at the same time [Variable; LTD Benefits] are payable.]**

[Optional;

[Variable; The Monthly Retirement Contribution Benefit] will first be applied to reduce any overpayment of your claim.]

When [Variable; The Monthly Retirement Contribution] Ends. **[Variable; Monthly Retirement Contribution Benefits]** end automatically on the earliest of:

- * The date your **[Variable; LTD Benefits]** end.
- * **[Variable; The date you withdraw any funds from any retirement plan the Company contributed to for you under this Policy –or- The date you (a) begin withdrawing a monthly benefit or annuity, (b) withdraw contributions and/or interest, or (c) are required to withdraw or take a distribution of contributions and/or interest, from your Employer's retirement plan].**

[Optional;

- * The date your Employer's retirement plan or the trust is no longer able to accept the Monthly Retirement Contribution Benefit.]

[Optional;

- * The date continued contributions may cause your Employer's retirement plan to be disqualified.]

[Optional;

- * The date your employment is terminated by you or your Employer, unless your Employer's retirement plan document allows continued contributions on your behalf after such date.]

[Optional;

- * The date you begin employment with another employer or are self employed, or return to work for your Employer.]

[Optional;

Time Limits On Filing Proof Of Loss. Proof Of Loss for **[Variable; the Monthly Retirement Contribution Benefit]** must be provided within 90 days after the date you meet all the requirements shown in **[Variable; the Monthly Retirement Contribution Benefit]** Requirements above. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.]

[Optional;

Conversion of [Variable; Monthly Retirement Contribution Benefit] coverage. The [Variable; Monthly Retirement Contribution Benefit] coverage may **[Optional; not]** be converted under the Conversion Of Insurance provision.]]

- b. In the **Specifications** section, **SECTION 2. BENEFITS** is also amended to add the following language:

[Optional;

[Variable; 2.18] [Variable; MONTHLY RETIREMENT CONTRIBUTION BENEFIT]

Amount:

The smallest of the following:

[Optional;

- * **[Variable;** ranges from 1 to 25% of the first \$**[Variable;** ranges from 1 to 25,000] of your Predisability Earnings, but not to exceed] \$**[Variable;** ranges from 1 to 25,000];]

[Optional;

- * The amount your Employer's retirement plan may accept according to the retirement plan's definition of compensation for you;]

[Optional;

- * The monthly average amount your Employer contributed to your Employer's retirement plan on your behalf during the 12 calendar months preceding the date you became Disabled.]]

10. In order to add an **ANNUITY CONTRIBUTION BENEFIT**, the Group Policy is amended as follows:

- a. **SECTION 2. BENEFITS** is amended to add the following language:

[Optional;

[Variable; 2.19] ANNUITY CONTRIBUTION BENEFIT

Annuity Contribution Benefit Requirements. If you meet all of the requirements below the Company will pay an Annuity Contribution Benefit according to the terms of the Policy after the Company receives Proof Of Loss satisfactory to the Company.

Requirements For The Annuity Contribution Benefit:

[Optional;

- * You are **[Optional; not]** participating in your Employer's **[Variable; 403(b)]** retirement plan on the date of your Disability.]
- * You are Disabled and **[Variable; LTD Benefits]** **[Optional; are payable to you -or- have been payable to you for [Variable; 1-10 years].]**

[Optional;

- * You are entitled to Social Security disability benefits; and are receiving such benefits; or are receiving Social Security early retirement benefits or widow's or widower's benefits; or Social Security disability benefits are not payable because they are being reduced by other income you receive.

If, in the Company's sole discretion, you are not entitled to Social Security disability benefits solely because you have not earned the required minimum number of quarters for Social Security coverage, you will be considered to have met this requirement for the purposes of being eligible for this benefit.]

- * You submit a signed application for the annuity that the Company will purchase for you and any other information required by the annuity provider the Company selects.]

Annuity Contribution Benefit Amount. The amount of the Annuity Contribution Benefit will be **[Optional; [Variable; 1 to 25]%** of the first **[\$[Variable;1 to 25,000]** of your Predisability Earnings, but not to exceed **[Optional; \$[Variable; 50 to 15,000]]**. The Annuity Contribution Benefit is not reduced by Other Income. **[Optional; The minimum Annuity Contribution Benefit payable will be \$[Variable; 25 to 500].**

[Optional;

If the Annuity Contribution Benefit is includable in your gross income for federal income tax purposes, the Company will increase your Maximum Benefit percentage by **[Variable;1 to 10]** percentage points while the Annuity Contribution Benefit is payable. For example, if your Maximum Benefit percentage is **[Variable; 60%]**, as shown in the **Specifications**, it will be increased to **[Variable; 61%]**. This change will be effective when the Annuity Contribution Benefit becomes payable and will not be retroactive to any time period prior to the Annuity Contribution Benefit being payable.]

Payment Of The Annuity Contribution Benefit. The Company will purchase an annuity for you from a company and of a type the Company determines using the Company's sole discretion. The Annuity Contribution Benefit will be paid as premiums into this annuity. The Annuity Contribution Benefit will not be paid directly to you.

However, if the Company determines that the Annuity Contribution Benefit is likely to only be paid for **[Variable; 12 to 60]** months or less, due to the Maximum Benefit Period or some other limiting factor, or if you reside in a jurisdiction where the Company does not have a relationship with an annuity carrier doing business in that jurisdiction, then, at the Company's discretion, it will not purchase an annuity for you and the Annuity Contribution Benefit will instead be paid directly to you. In this situation you will not be required to submit a signed application form for an annuity.

The Company will pay the Annuity Contribution Benefit within 30 days after Proof Of Loss is satisfied and your signed application for the annuity is approved by the annuity carrier the Company selects. **[Optional; Your Annuity Contribution Benefit will be paid at the same time [Variable; LTD Benefits] are payable.]**

[Optional;

The Annuity Contribution Benefit will first be applied to reduce any overpayment of your claim.]

When The Annuity Contribution Benefit Ends.

Annuity Contribution Benefits **[Optional;** and any corresponding increase in your **[Variable; LTD Benefits]]** end automatically on the earliest of:

- * The date your **[Variable; LTD Benefits]** end.
- * The date you withdraw any funds from any annuity the Company contributed to for you under this Policy.

[Optional;

- * The date you execute an exchange under Section 1035 of the IRC of an annuity the Company contributed to for you under this Policy.]

[Optional;

Time Limits On Filing Proof Of Loss. Proof Of Loss for the Annuity Contribution Benefit must be provided within 90 days after the date you meet all the requirements shown in the Annuity Contribution Benefit Requirements above. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.]

[Optional;

Conversion of Annuity Contribution Benefit coverage. The Annuity Contribution Benefit coverage may **[Optional; not]** be converted under the Conversion Of Insurance provision.]]

- b. In the **Specifications** section, **SECTION 2. BENEFITS** is also amended to add the following language:

[Optional;


[Variable; 2.19] [Variable; MONTHLY ANNUITY CONTRIBUTION BENEFIT]

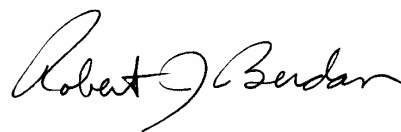
Amount:

The amount of the Annuity Contribution Benefit will be **[Optional; [Variable; 1 to 25]% of the first \$[Variable; 1 to 25,000] of your Predisability Earnings, but not to exceed [Optional; \$[Variable; 50 to 15,000]].** The Annuity Contribution Benefit is not reduced by Other Income. **[Optional; The minimum Annuity Contribution Benefit payable will be \$[Variable; 25 to 500].]**

The Northwestern Mutual Life Insurance Company

By


President and C.E.O.


Secretary

<i>SERFF Tracking Number:</i>	<i>NWST-126046916</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Northwestern Mutual Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42030</i>
<i>Company Tracking Number:</i>	<i>MN 992-LTD/0209</i>		
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.003 Long Term</i>
<i>Product Name:</i>	<i>MN 992-LTD/0209</i>		
<i>Project Name/Number:</i>	<i>MN 992-LTD/0209/MN 992-LTD/0209</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: NWST-126046916 State: Arkansas
Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number: 42030
Company Tracking Number: MN 992-LTD/0209
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term
Product Name: MN 992-LTD/0209
Project Name/Number: MN 992-LTD/0209/MN 992-LTD/0209

Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 04/06/2009
Comments:
Attachment:
AR Read.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 04/06/2009
Comments:
The application number MN-18-91-1658 to be used for this rider filing was approved on December 30, 1987.

CERTIFICATION OF READABILITY

State of Arkansas

Form Number	Flesch Readability Score
MN 992-LTD/0209	43.2
MN 992-LTDC/0209	43.2

I certify that to the best of my knowledge and belief, the above-referenced form(s) meet or exceed the readability, legibility, and format requirements of any applicable laws and regulations in the state of Arkansas.

The Northwestern Mutual Life Insurance Company



Signature

Ted Matchulat

Name

Director, Product Compliance

Title

Date